Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ORTHOTEXAS PHYSCIANS AND SURGEON

Respondent Name
HARTFORD UNDERWRITERS INSURANCE CO

MFDR Tracking Number
M4-16-2245-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
APRIL 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "See the attached dictation that supports the services rendered."

Amount in Dispute: $90.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation has fount that Code J0702 was denied for a valid NDC number(s). To date, we have not received a corrected billing with a valid NDC number(s).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 2, 2015 December 24, 2015	HCPCS Code J0702 (X6) Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg	$90.00	$40.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - 940-Please re-submit with the appropriate NDC number, no AWP for this NDC.
   - W3-Additional payment on appeal/reconsideration.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.
   - 982-Please re-submit with the appropriate NDC number.
   - 1115-We find the original review to be accurate and are unable to recommend any additional allowance.

Issues

Is the requestor entitled to reimbursement for HCPCS code J0702?

Findings

On the disputed date of service, the requestor billed for HCPCS code L0637-NU based upon reason codes "16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate," and "982-Please re-submit with the appropriate NDC number." The requestor noted in the progress notes code J0702 was injected to claimant. The submitted billing indicates HCPCS code J0702 was billed; therefore, the respondent's denial is not supported.

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

Per 2015 NCCI Policy Manual for Medicare Services, Chapter 12, (A) "The HCPCS Level II codes are alpha-numeric codes developed by the Centers for Medicare and Medicaid Services (CMS) as a complementary coding system to the *CPT Manual*. These codes describe physician and non-physician services not included in the *CPT Manual*, supplies, drugs, durable medical equipment, ambulance services, etc." HCPCS code J0702 is a HCPCS Level II code. Therefore, the guidelines outlined in 28 Texas Administrative Code §134.203(d)(1-3) apply to the disputed service.

28 Texas Administrative Code §134.203(d)(1-3) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

(1) "125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

HCPCS code J0702 does not have a fee listed in DMEPOS fee schedule for Texas.

(2) "if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS."

HCPCS code J0702 has a fee of $5.42 listed in Texas Medicaid fee schedule; therefore, the MAR is $5.42 X 125% = $6.78 X 6 units billed = $40.65; this amount is recommended in reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $40.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $40.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	6/9/2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.